RULES
OF
TENNESSEE DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES

CHAPTER 1240-3-3
TECHNICAL AND FINANCIAL ELIGIBILITY
REQUIREMENTS FOR MEDICAID

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1240-3-3-.01 NECESSITY AND FUNCTION. The Department of Human Services has responsibility to administer the program of Medicaid Assistance in accordance with requirements of Title XIX of the Social Security Act. *T.C.A. §§14-722 and 14-1902* empower the Department to comply with any requirement that may be imposed or opportunity presented by Federal law for the provision of medical assistance to Tennessee's indigent citizenry. federal regulations set for the resource and income standards and the technical requirements by which eligibility for Medicaid is determined. 42 C.F.R. 435.400, 435.500, 435.600, 435.700 and 435.800.

Authority: *T.C.A. §§14-722, 14-1911, 14-22-204, and 14-23-111.* ***Administrative History:*** *Repeal and new rule filed June 14, 1976; effective July 14, 1976. Amendment filed August 17, 1982; effective September 16, 1982.*

1240-3-3-.02 TECHNICAL ELIGIBILITY FACTORS. To be eligible for Medicaid, families or individuals, whether classified as Categorically Needy or Medically Needy, must meet the following requirements, where applicable:

(1) Children otherwise covered under 1240-3-2-.02(3) or adults must not be inmates of a public institution, as that term is defined by Federal regulations and policy.

(2) An aged individual must be at least 65 years of age.

(3) A blind individual must meet the definition of blindness as contained in Title II and XVI of the Social Security Act relating to OASDI and SSI, 42 C.F.R. §435.530.

(4) A disabled individual must meet the definition of permanent and total disability as contained in Titles II and XVI of the Social Security Act relating to OASDI and SSI. Eligibility based on disability is determined in accordance with requirements set out by Titles XVI and XIX of the Social Security Act , 42 C.F.R. §§435.540, 435.541, and 435.911. As Tennessee is a 1634 State, the disability decision made by the Social Security Administration (SSA) for Supplemental Security Income (SSI) applicants is binding on the State Agency's decision for Medicaid only based on disability except when the individual applies for:

(a) Medicaid only and has not applied for SSI or has applied for SSI but was ineligible for a reason other than disability; or

(b) SSI at the Social Security Administration and applies to the State Agency for Medicaid only and the Social Security Administration does not make a disability determination within 90 days from the date of application for Medicaid only; or

(c) Medicaid only and alleges that a different or additional disabling condition exists and was not considered by the Social Security Administration; or

(Rule 1240-3-3-.02, continued)

(d) Medicaid only more than 12 months after SSI disability denial and alleges that the disabling condition has changed or deteriorated or applies in less than 12 months of the Social Security Administration's determination alleging his/her condition has changed/deteriorated but the Social Security Administration refused to consider these new allegations and/or he/she is no longer financially or technically (other than disability) eligible for SSI.

(5) An individual must be a citizen of the United States, a lawfully admitted alien, or an alien permanently residing in the United States under color of law, in accordance with Section 1903(v)(1), of the federal Social Security Act (42 U.S.C. § 1396b(v)(1)) unless applying for emergency medical services assistance as an illegal or undocumented alien or one lawfully admitted for residence who is not aged, blind, disabled, or under age 18.

(6) An individual must be a resident of the State of Tennessee, as defined by federal regulations at 42 C.F.R. § 435.403, Tennessee Code Annotated § 71-5-120, and as further defined by the Bureau of TennCare.

(7) Reserved.

(8) By accepting medical assistance through the Medicaid program, every recipient is deemed to assign to the State of Tennessee all third party insurance benefits or other third party sources of medical support or benefits. Failure to cooperate in establishing the paternity of dependent children, or in securing or collecting third party medical insurance, benefits or support is grounds for denying or terminating medical eligibility.

(9) Institutionalized individuals in a medical institution (i.e., one organized to provide medical care, including nursing and convalescent care or Home and Community Based Services [HCBS]) must be continuously confined for thirty (30) consecutive days prior to attaining Medicaid eligibility based on institutionalization. Medicaid coverage is retroactive to the date of admission when thirty (30) consecutive days of institutionalization is met and may begin up to three (3) months prior to the month of application, if otherwise eligible.

(10) As a condition of receiving medical assistance through the Medicaid program, each applicant or recipient must furnish his or her Social Security Number (or numbers, if he/she has more than one) during the application process. If the applicant/recipient has not been issued a number, he/she must assist the eligibility worker in making application for a number or provide verification that he/she has applied for a number and is awaiting its issuance.

Authority: *T.C.A. §§4-5-201 et seq., 71-1-105(12); 71-5-120; 71-5-141; 42 USC §§1382c(a)(3)(.4), 1396a(a)(10)(A)(ii)(I) and (V), and 1396b(v)(1); 42 C.F.R. §§435.210, 435.300, 435.301, 435.403, 435.530, and 435.540.* ***Administrative History:*** *Repeal and new rule filed June 14, 1976; effective July 14, 1976. Amendment filed September 15, 1977; effective October 14, 1977. Amendment filed June 9, 1981; effective October 5, 1981. Amendment filed August 28, 1981; effective November 30, 1981. Amendment filed November 30, 1981; effective January 14, 1982. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed September 4, 1984; effective October 4, 1984. Amendment filed September 19, 1985; effective October 19, 1985. Amendment filed May 23, 1986; effective August 12, 1986. Amendment filed July 31, 1987; effective September 13, 1987. Amendment filed August 9, 1989; effective September 23, 1989. Amendment filed August 17, 1992; effective October 8, 1992. Amendment filed December 30, 1993; effective March 15, 1994. Amendment filed June 5, 1995; effective August 18, 1995. Amendment filed May 1, 2003; effective July 15, 2003.*

1240-3-3-.03 RESOURCE LIMITATIONS FOR CATEGORICALLY NEEDY.

(1) Applicants for medical assistance as Categorically Needy in an AFDC related coverage group are

permitted to retain resources as described in rule 1240-1-4-.02 pertaining to the AFDC cash assistance program. Excluded resources are those excluded in the AFDC program as reflected in rule 1240-1-4-.05 and countable resources are determined by using the AFDC policy reflected in rule 1240-1-4-.07. Lump-sum payments are treated in accordance with rule 1240-1-4-.28.

(2) Applicants for medical assistance as Categorically Needy in an SSI-related category are permitted to retain resources in an amount not to exceed SSI limits except for Qualified Medicare Beneficiaries (QMBs), Special Low Income Medicare Beneficiaries (SLIMBs), Special Low Income Beneficiaries (SLIBs) Qualifying Individuals 1 and 2 (QI1 and QI2), and Qualified Disabled Working Individuals who are permitted to retain resources in an amount not to exceed two hundred percent (200%) of the SSI limits.

(a) Resources excluded from consideration in determination of eligibility for medical assistance are:

1. For SSI related cases (aged, blind, and disabled individuals):

(i) A homestead of unlimited value, if used as a home by the applicant/recipient, spouse, and/or dependent relative. If absent from the home with intent to return, an individual may retain a homestead for an unlimited period of time.

(ii) All life insurance, if the total face of all policies does not exceed $1500 per owner.

(iii) One motor vehicle of unlimited value is excluded in its entirety, if it meets any one of the following conditions:

(I) It is necessary for employment; or

(II) It is necessary to obtain medical treatment of a specific or regular medical problem; or

(III) It has been modified for operation by or transportation of a handicapped person; or

(IV) It is necessary because of climate, terrain, distance, or similar factors to provide transportation to perform essential daily activities.

I. If no motor vehicle is excluded under the above provisions, one motor vehicle is excluded to the extent equity value does not exceed forty six hundred dollars ($4,600). If the equity value exceeds forty six hundred dollars ($4,600), the excess is counted against the resource limit.

II. The equity value of any other motor vehicle is counted unless also excludable under 1240-3-3-.03(2)(a)1.(iii) above or qualified as property under an approved plan for self-support or necessary for self-support in a business or non-business income producing activity. If no motor vehicle is excluded under the above provisions, one motor vehicle is excluded to the extent equity value does not exceed forty six hundred dollars ($4,600). If the equity value exceeds forty six hundred dollars ($4,600), the excess is counted against the resource limit.

(Rule 1240-3-3-.03, continued)

III. The equity value of any other motor vehicle is counted unless qualified as property under an approved plan for self-support or necessary for self-support, in a business or non-business income producing activity, or fifteen hundred dollars ($1,500) of the equity value is set aside for burial reserve.

(iv) Personal effects and household goods of two thousand dollars ($2,000) or less equity value.

(v) All income-producing property, tools, equipment, government permits used in trade or business regardless of rate of return and non-business resources if the rate of return is at least six percent (6%) of the equity value of the resource or within reasonable limits of similar property in the area. Exclude as essential to self-support up to six thousand dollars ($6,000) of an individual's equity in income-producing property if it produces a net annual income to the individual of at least 6% of the excluded equity.

(vi) Burial space for self, spouse and immediate family members.

(I) Burial space is defined to include conventional grave sites, crypts, mausoleums, urns, or other repositories which are customarily and traditionally used for the remains of deceased persons.

(II) Immediate family includes the applicant's or recipient's minor and adult children, step-children, adopted children, brothers, sisters, parents, adoptive parents, and spouses of these persons.

(vii) Funds, which are not commingled, are subject to the limits specified below, which are designated as set aside for expenses connected with the individual's burial, cremation or other funeral arrangements.

(I) The maximum revocable amount which may be set aside is fifteen hundred dollars ($1,500) for the applicant/recipient and fifteen hundred dollars ($1,500) for his/her spouse.

(II) The maximum revocable amount is reduced by an amount equal to funds held in an irrevocable burial trust, contract or agreement.

(III) The maximum irrevocable burial fund, agreement or contract established by the individual is six thousand dollars ($6,000) plus cost of transporting the body.

(IV) Irrevocable burial contract or agreements established by a funeral home/director for an individual must be a reasonable amount and must have an itemized list of costs, goods and services that reflect fair market value.

(viii) Other resources determined to be unavailable to the applicant/recipient due to circumstance beyond his/her control.

(b) In SSI related cases all other resources such as, but not limited to bank accounts, money on hand, stocks, bonds, cash value of life insurance on which the total face value exceeds $1500, real property other than income-producing and homestead property (including cemetery plots not exempt in 1240-3-3-.03), non-excluded motor vehicles and revocable burial agreements, unless

exempt as in l240-3-3-.03(2)(a)l.(iii) shall be counted toward the resource limit per family size.

(c) Resource eligibility will exist for the entire month, if the applicant/recipient's total countable resources are at or below the resource limit at any time during the month in question.

(3) Transfer of Assets.

(a) Effective August 11, 1993 any transfers taking place on or after that date (and within thirty-six (36) months of applying for Medicaid on or after August 1, 1993) in which an asset was transferred for less than fair market value will be considered an available asset. This policy applies to currently institutionalized individuals and to non-institutionalized individuals who later enter an institution, who have transferred assets for less than fair market value on or after August 1, 1993 and who apply for Medicaid as an institutionalized individual within thirty-six (36) months of such transfer.

1. Countable assets for this provision include all real and personal property except a home and title transferred to the individual's

(i) Spouse;

(ii) Minor child under age twenty-one (21) or adult disabled or blind child;

(iii) Sibling who has equity interest and has resided in the home for at least one (1) year prior to the individual's institutionalization;

(iv) Child [other than those in (ii) above] who resided in the home at least two (2) years immediately preceding the individual's institutionalization and who provided care that permitted the individual to stay in the home rather than a medical or nursing facility; or

(v) To another for the sole benefit of the community spouse or the individual's child who is blind or permanently and totally disabled, or under age twenty-one (21).

2. The period of ineligibility for nursing home vendor or waivered services under Home and Community Based Services for assets transferred within thirty-six (36) months (sixty (60) months of establishing an irrevocable trust) of application for long term care nursing services or home and community based services will be the lesser of the uncompensated value divided by the average monthly nursing home charge at the private rate. There is no limit on the maximum months of ineligibility. The penalty continues until expired unless hardship is considered to exist and the institutionalized individual has no available resources (other than the uncompensated value) in excess of the resource limitations and the application of the penalty will result in loss of essential nursing care, which is not available from any other source.

(b) Effective October 1, 1993, the following situations may be considered a transfer of assets for less than fair market for an individual applying for Medicaid based on institutionalization, if the action occurred on or after August 11, 1993. The institutionalized individual may be subject to penalty, if the transfer was completed by himself/herself; the individual's spouse; a person (including a court) or administrative body with legal authority to act in place of, or on behalf of, or at the direction or request of the institutionalized individual or his/her spouse. Assets include all income and resources, including the home unless transferred as indicated in (a) above of the institutionalized individual and his/her spouse (including income and/or resources the individual is entitled to), but does not receive, because of any action by the individual or his/her spouse, or

a person (including a court) or administrative body with legal authority to represent the individual, his/her spouse, or who acts at the direction or request of the individual and his/her spouse.

1. Transfer of Assets for less than fair market value occurs on or after August 11, 1993 and within thirty-six (36) months of application as an institutionalized individual.

2. Establishment of a trust or similar device by the institutionalized individual, his/her spouse, or any person, court or administrative body with authority to act on behalf, or at the direction, or request of the individual or his/her spouse which includes the individual's assets and cannot be used by or for the individual's benefit, if it occurred within sixty (60) months of application as an institutionalized individual or within thirty-six (36) months of application if an irrevocable trust is established which allows payments to or on behalf of the individual.

3. An asset held jointly by the institutionalized individual with another person will be considered a transfer of assets by the individual, when the individual or other owner reduces or eliminates the institutionalized individual's ownership or control of the asset.

4. The transfer of assets will be subject to a penalty period of ineligibility for nursing home vendor or waivered services under Home and Community-Based Services (Medicaid eligibility continues for other services) determined by dividing uncompensated value of the transferred asset by the average monthly nursing home charge at the private pay rate unless satisfactory proof is provided that the individual intended to dispose of assets for fair market value; or assets transferred exclusively for a purpose other than to qualify for Medicaid; or transferred assets have been returned to the individual; or if it is determined that the penalty period would work an undue hardship as defined in (a) above.

(4) Funds paid into irrevocable burial agreements that are in compliance with *T.C.A. §62-5-401 et seq.* are not counted as a resource. The agreement must be irrevocable as provided in *T.C.A. §62-5-403(a)(2)*.

(5) Medicaid Qualifying Trust.

(a) Funds from a Medicaid qualifying trust, as defined below, are deemed to be available to the applicant/recipient as provided below when an application for Medicaid is filed on or after June 1, 1986 and a countable resource to that applicant/recipient.

(b) For purposes of this rule, a "Medicaid qualifying trust" is a trust, or similar legal device, established prior to August 11, 1993 (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

(c) The amounts from the trust deemed available to an applicant/recipient is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the applicant/recipient, assuming full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the applicant recipient.

(d) The provisions of this paragraph shall apply without regard to:

1. Whether or not the Medicaid qualifying trust is irrevocable or is established for purposes other than to enable an applicant/recipient to qualify for Medicaid; or

(Rule 1240-3-3-.03, continued)

2. Whether or not the discretion described in subparagraphs (b) and (c) is actually exercised.

(6) The funds of a Medicaid qualifying trust will not be deemed to be an available resource to an applicant/recipient to the extent that doing so would result in undue hardship. For purposes of this rule, undue hardship shall only exist when:

(a) The funds in the trust have been, or are being expended on necessities such as clothing, food and shelter, the loss of which was caused by a natural or casualty disaster, and such losses are not covered by any third party liability.

(b) The funds in the trust have been or are being expended on funeral and/or burial expenses of an immediate family member.

(c) The funds in the trust have been or are being expended to prevent or rectify a situation which endangers the health and well-being of the applicant/recipient and/or his/her immediate family.

(7) Assessment of Resources and Community Spouse Resource Allowance.

(a) Resources owned by either spouse or by both spouses are considered equally available to both spouses at the beginning of a continuous period of institutionalization (i.e., 30 consecutive days in nursing care) for persons institutionalized after September 30, 1989. If an assessment of resources is requested by the institutionalized or community spouse or either's authorized representative, an assessment will be made within 30 days of receipt of all relevant documentation from the requesting party(ies). If either spouse is dissatisfied with this Department's assessment, either spouse has a right to a fair hearing with respect to the determination of the community spouse's resource allowance at the point an application for Medicaid has been filed. This hearing must be held within thirty (30) days of the date a request for hearing is made.

(b) The community spouse resource allowance is equal to the greater of;

1. One-half of the total resources owned by both spouses not to be less than seventeen thousand, eight hundred, fifty-six dollars ($17,856) nor greater than eighty-nine thousand, two hundred, eighty dollars ($89,280);

2. The amount established after a fair hearing by the Department of Human Services on the issue has been concluded; or

3. The amount transferred under a court order against the institutionalized spouse for the support of the community spouse.

In all actions for the transfer of income or resources from an institutionalized spouse for the support of the community spouse, the court shall apply the standards utilized to determine Medicaid eligibility in this state, regardless of any state laws relating to community property or the division of marital property.

(c) Spouses must be legally married pursuant to the laws of the State of Tennessee; and

(d) The community spouse resource allowance determined by the assessment will be deducted from the value of all available resources owned by both spouses as of the first month for which assistance is requested. After the initial month of eligibility, no resources of the community spouse will be considered available to the institutionalized spouse.

(Rule 1240-3-3-.03, continued)

Authority: *T.C.A. §§4-5-201 et seq., 4-5-202, 71-1-105(11) and (12), 71-5-106, 71-5-111, and 71-5-121; 20 C.F.R. §§416.1205(c), and 416.1212; 42 C.F.R. §§435.914(b)(c), 435.85, 435.700, 435.721(b), 435.831, and 435.851; PL 97-248, PL 98-369 §2611, PL 99-509 §9401(a)(3), and PL 100-93 §9; 42 USC §§1396d(p) and (s) and 1396r-5(b), (d), (f) & (g); OBRA 1989 §8014 and OBRA 1993.* ***Administrative History:*** *Repeal and new rule filed June 14, 1976; effective July 14, 1976. Amendment filed September 15, 1977; effective October 14, 1977. Amendment filed July 27, 1978; effective October 30, 1978. Amendment filed June 9, 1981; effective October 5, 1981. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed February 28, 1983; effective March 30, 1983. Amendment filed January 30, 1985; effective March 1, 1985. Amendment filed February 26, 1985; effective March 28, 1985. Amendment filed March 31, 1986; effective April 30, 1986. Amendment filed April 15, 1986; effective July 14, 1986. Amendment filed August 20, 1986; effective October 4, 1986. Amendment filed May 8, 1987; effective August 29, 1987. Amendment filed July 31, 1987; effective September 13, 1987. Amendment filed February 26, 1988; effective May 29, 1988. Amendment filed March 7, 1988; effective June 29, 1988. Amendment filed April 8, 1988; effective July 27, 1988. Amendment filed August 9, 1989; effective September 23, 1989. Amendment filed January 31, 1990; effective March 17, 1990. Amendment filed May 1, 1991; effective June 15, 1991. Amendment filed December 30, 1993; effective March 15, 1994. Amendment filed April 23, 1997; effective July 7, 1997. Amendment filed October 26, 2001; effective January 9, 2002. Amendment filed May 1, 2003; effective July 15, 2003.*

1240-3-3-.04 INCOME LIMITATIONS FOR CATEGORICALLY NEEDY.

(1) Applicants for medical assistance as Categorically Needy in an AFDC related coverage group are subject to income definitions and policies of the AFDC program as specified in rules 1240-1-4-.12, 1240-1-4-.14 through 1240-1-4-.21 and 1240-1-4-.23 through 1240-1-4- .26, except that the Poverty Level Income Standard (PLIS) is used for applicants/recipients in the coverage groups specified in 1240-3-2-.02(2)(k), (l), (q) and (t).

(2) Except as otherwise provided in paragraph (3) of this rule, SSI-related coverage groups are subject to income definitions and policies mandated in 42 C.F.R. §§435.721 through 435.725 and 42 C.F.R. §435.1005.

(a) Any aged, blind or disabled individual confined to long term nursing care in a facility or in Home and Community Based Services (HCBS) for at least 30 consecutive days may have countable income equal to or less than 300% of the SSI/FBR beginning the month of admission.

(b) The otherwise eligible individual confined to a long-term care facility is required to assume some of his/her cost of care.

1. Personal Needs Allowance: $30 for an individual.

2. Spousal/dependent allocation not to exceed two thousand, one hundred, three dollars ($2,103) per family which includes:

(i) the spousal allocation using a standard maintenance amount (SMA) based upon one hundred fifty percent (150%) of the federal poverty level for two (2) persons for one (1) year divided by twelve (12) months, minus the community spouse's available countable income in addition to excess shelter expenses that exceed thirty percent (30%) of the SMA, in addition to

(ii) The dependent allocation which equals the SMA minus each dependent's gross countable income divided by three. Department relatives include all individuals who can be or are claimed for Federal income tax purposes by either spouse; and

(Rule 1240-3-3-.04, continued)

(iii) The Medically Needy Income Standard (MNIS) will be used to determine the dependent allocation when there is no community spouse.

(c) Qualified Medicare Beneficiaries may be income eligible if such an individual's total income does not exceed 100% of Federal Poverty Guidelines.

1. 85% effective as of January 1989.

2. 90% effective as of January 1990.

3. 95% effective as of January 1991.

4. 100% effective as of January 1992.

(d) The otherwise eligible individual confined to a long-term care facility is required to assume some of his/her cost of care.

The following deductions are made from the total income available for the cost of long-term nursing home care in the following order:

1. Personal needs allowance: $30 for an individual.

2. Allocation to eligible dependent(s) at home reduced by the amount of the dependent's own income.

3. Monthly costs for health insurance premium(s) paid by the eligible individual.

4. Payments for medical or remedial care recognized under state law, but not encompassed within the State's Medicaid plan subject to the following criteria.

Non-Covered Medical Expenses

(i) Reserved for future use.

(ii) Eyeglasses and necessary related services. Deductions can only be made for the following services and must be the lesser of the provider's usual and customary charges, billed charges, or the amounts indicated in this rule.

Examination and refraction	$50.00
Frame	$50.00
Lenses (bifocal)	$20.00 ($10.00 each)
Lenses (single)	$15.00 ($7.50 each)

(iii) Hearing aids and necessary related services. Deductions can only be made for the following services and must be the lesser of the provider's usual and customary charges, billed charges, or the amounts indicated in this rule.

Audiogram	$60.00
Ear mold	$30.00
Hearing aid	$400.00
Batteries	$5.00 per package
Hearing aid orientation	$60.00 per hour (not to exceed $120.00)

(Rule 1240-3-3-.04, continued)

(iv) Dental services.

(I) In addition to the deductions from the total income available for the cost of long-term nursing home care authorized by rules and regulations of the Department of Human Services, Division of Medical Services for an eligible individual confined to a long-term care facility, a deduction shall also be authorized and made from such total income available for the costs of routine and emergency dental services paid by the eligible individual.

(II) Deductions for such routine and emergency dental services, as defined by the Bureau of TennCare, shall only be made for those purposes and in such amounts as determined annually by the Bureau of TennCare's dental fee listing, whether such services are provided at a dental office, on-site at the long-term care facility, or through a mobile dental services provider that contracts with the long-term care facility.

(v) Specialized chairs such as electric wheelchairs. Deductions will be restricted to the lesser of the Medicare prevailing charges or the Medicaid established fee.

5. Patient liability overcharge adjustment.

(e) Qualified Disabled Working Individual may be income eligible, if the individual income does not exceed 200% of the Federal Poverty Guidelines.

(f) Special Low Income Medicare Beneficiaries (SLMB) may be income eligible, if the individual's income does not exceed 120% of Federal Poverty Guidelines.

(g) Qualified Individuals 1 (QI-1) may be income eligible if the individual's income does not exceed one hundred thirty-five percent (135%) of Federal Poverty Guidelines.

(h) Qualified Individuals 2 (QI-2) may be income eligible if the individual's income does not exceed one hundred seventy-five percent (175%) of Federal Poverty Guidelines.

(3) Post-eligibility treatment of income for individuals participating in the State's Home Community Based Project will be determined as follows:

(a) Total gross income will consist of the eligible individual's own income after deduction of the personal needs allowance (maintenance need based on the SSI/FBR for an individual living in the home) has been made for the participating individual and spouse, if applicable.

(b) An allocation will be made to the community spouse and/or dependents as indicated in Paragraph (2)(b)2. herein.

(c) Deductions cited in 1240-3-3-.04(2)(d) will be made from the total gross income with the exception of the personal needs allowance.

Authority: *T.C.A. §§4-5-201 et seq., 4-5-202, 71-1-105(12), 71-5-103, 71-5-106, 71-5-111, and 71-5-140; 42 USC §1302; 42 C.F.R. §§435.725(d) as amended; 53 Federal Register 3586 (February 8, 1988); 42 C.F.R. 435.726, 42 C.F.R. 435.845, 435.735, and 435.722; PL 100-203 §4065, PL 99-272, PL 100-360 §301, and PL 100-360 §303; 42 USC §1396r-5; 42 C.F.R. §§435.722, 435.725, and 435.726; 42 USC §§1396a(a)(10) and 1396a(1), (q) and (r); 42 USC §1396d(p) and (s); 42 USC §§ 1396r-5(b) and 5(d)(3)(B) and (C).* ***Administrative History:*** *Repeal and new rule filed June 14, 1976; effective July 14, 1976. Repeal and new rule filed August 17, 1982; effective*

(Rule 1240-3-3-.04, continued)

September 16, 1982. Amendment filed June 27, 1985; effective July 27, 1985. Amendment filed July 31, 1987; effective September 13, 1987. Amendment filed August 5, 1988; effective November 29, 1988. Amendment filed November 30, 1988; effective January 14, 1989. Amendment filed August 9, 1989; effective September 23, 1989. Amendment filed May 1, 1991; effective June 15, 1991. Amendment filed April 23, 1997; effective July 7, 1997. Amendment filed October 26, 2001; effective January 9, 2002. Amendment filed May 1, 2003; effective July 15, 2003.

1240-3-3-.05 RESOURCE LIMITATIONS FOR THE MEDICALLY NEEDY.

(1) Applicants for medical assistance are permitted to retain resources in an amount not to exceed the SSI limits. An additional $100 in resources is allowed for each additional person in AFDC-related coverage groups over those provided for in the SSI regulations.

(2) Excluded Resources.

(a) Resources excluded from consideration in the determination of eligibility for AFDC-related medical assistance are those excluded in the AFDC cash assistance program in rule 1240-1-4-.05.

(b) Resources excluded from consideration for Adult and Institutionalized Medically Needy cases are those excluded by SSI regulations at 20 C.F.R. Part 416.

(3) Countable Resources.

(a) Countable resources for AFDC-related cases are determined by using the policies of the AFDC cash assistance program as reflected in rule 1240-1-4-.07.

(b) Countable resources for Adult Medically Needy cases are determined by using SSI policy at 20 C.F.R. Part 416 and as indicated in Rule 1240-3-3-.03(7) for institutionalized individuals with a spouse living in the community.

Authority: *T.C.A. §§ 71-1-105(12), 71-5-106, 14-722, 14-1911, 14-1-105, 14-20-204, 14-23-106, and 14-23-111; PL 98-369 §2611, PL 99-272 §§9501 and 9506; 20 C.F.R. §416.1205(c); 42 C.F.R. §§435.841, 435.845, 435.851; PL 100-360 §303; 42 USC §1396r-5.* ***Administrative History:*** *Repeal and new rule filed June 14, 1976; effective July 14, 1976. Amendment filed April 28, 1980; effective July 12, 1980. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed February 26, 1985; effective March 28, 1985. Amendment filed May 8, 1987; effective August 29, 1987. Amendment filed March 7, 1988; effective June 29, 1988. Amendment filed August 9, 1989; effective September 23, 1989. Amendment filed May 1, 1991; effective June 15, 1991. Amendment filed April 23, 1997; effective July 7, 1997.*

1240-3-3-.06 INCOME LIMITATIONS FOR MEDICALLY NEEDY.

(1) In adult medically needy cases, countable income is determined by using the Supplemental Security Income (SSI) program's income definitions and policies found at 20 C.F.R. Part 416. In medically needy cases for families and children, countable income is determined by using the AFDC cash assistance program's income definitions and policies. Refer to AFDC income rules 1240-1-4-.12, 1240-1-4-.14 through 1240-1-1-.19, 1240-4-.21, 1240-1-4-.23 through 1240-1-4-.26, and 1240-1-4-.28, with the following exceptions:

(a) The earned income disregard of thirty dollars ($30.00) plus one-third (1/3) of the remainder is granted in a medically needy case only if the applicant has received Families First/AFDC in at least one (1) of the last four (4) months. In such a situation the disregard is applied only for a four (4) month period.

(Rule 1240-3-3-.06, continued)

(b) The maximum cap or gross income of one hundred eighty-five percent (185%) of the Families First/AFDC need standard does not apply to medically needy due to the spend-down provision.

(2) Persons applying as Medically Needy must have a deduction for incurred cost of medical/health insurance premiums, deductibles and co-payments.

(a) Costs incurred for medical insurance premiums, co-payments and deductibles; and

(b) Expenses incurred for necessary medical and remedial services that are recognized under State law, but not included in the State plan for medical assistance.

(3) Determination of countable income of an individual or family.

(a) The countable income of an individual or family, once determined, is tested against the following standard, depending upon the number of individuals for whom application is made:

Size of Family	Monthly
1	Two hundred forty-one dollars ($241) (effective July 1, 1999)
2 and above	One hundred thirty-three and one-third percent (133 1/3%) of the maximum money payment which could be made to a family of the same size under Families First/AFDC

(Refer to AFDC Manual for payment levels and ratably reduced standard of need.)

(4) Medical and remedial expenses that are included in the State plan and incurred outside a Medicaid/TennCare eligibility period and those recognized under State Law, but not included in the State plan, which are incurred during the spend-down period or earlier, but remain unpaid, collectible, and the client's responsibility, or which have been reimbursed by another State or local program and health insurance premiums are applied to any excess income for the same period. The spend-down period is one month and eligibility is determined monthly.

(5) Patient liability for institutionalized individuals whose gross income exceeds the categorical medicaid income cap will be determined by using the deductions listed within rule 1240-3-3-.04(2)(d) and by comparing the remainder to the medicaid reimbursement rate for the long-term care being provided.

Authority: *T.C.A. §§4-5-202, 71-1-105(12) and 71-5-106; 42 USC §1396a(a)(10)(A)(ii)(I); 42 C.F.R. 435.210, 435.300, and 435.301; 42 USCA §1396a(a)(17)(D) and (q); 42 C.F.R. §§435.831, 435.832, and 435.1007.* ***Administrative History:*** *Repeal and new rule filed June 14, 1976; effective July 14, 1976. Amendment filed September 15, 1977; effective October 14, 1977. Amendment filed June 9, 1981; effective October 5, 1981. Repeal and new rule filed August 17, 1982; effective September 16, 1982. Amendment filed September 4, 1984; effective October 4, 1984. Amendment filed May 23, 1986; effective August 12, 1986. Amendment filed July 23, 1986; effective October 29, 1986. Amendment filed May 8, 1987; effective August 29, 1987. Amendment filed March 7, 1988; effective June 29, 1988. Amendment filed April 8, 1988; effective July 27, 1988. Amendment filed August 9, 1989; effective September 23, 1989. Amendment filed May 1, 1991; effective June 15, 1991. Amendment filed August 17, 1992; effective October 8, 1992. Amendment filed December 30, 1993; effective March 15, 1994. Amendment filed April 23, 1997; effective July 7, 1997. Amendment filed October 26, 2001; effective January 9, 2002.*

(Rule 1240-3-3-.06, continued)